

NOTICE OF INDEPENDENT REVIEW DECISION

March 25, 2002

RE: Injured Worker:

MDR Tracking #: M2-02-0473-01

IRO Certificate #:

The independent review was performed by a _____ physician reviewer who is board certified in anesthesia and pain management which is the same specialty as the treating physician. The _____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to _____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

The _____ physician reviewer has determined that the proposed care is not medically necessary for treatment of the patient's condition. Therefore, ____ agrees with the previous adverse determination. The specific reasons including the clinical basis for this determination are as follows:

This 34-year-old female sustained a cervical injury after lifting heavy boxes _____. The patient was diagnosed with cervical radiculopathy, bilateral cervical facet syndrome, cervical discogenic pain, and myofascial cervical pain syndrome. The medical record documentation indicates that the patient underwent radio frequency lesioning of the bilateral cervical facet joints emphasizing the upper and lower facets on 12/14/00. At the return office evaluation on 04/10/01, the patient was complaining of persistent headaches. There is no indication that the radio frequency procedure provided long term relief. In addition, there is no evidence of symptom magnification. Therefore, based on the medical record documentation, there is no indication for a repeat radio frequency lesioning of the bilateral cervical facet joints emphasizing the upper and lower facets.

This decision by the IRO is deemed to be a TWCC decision and order.

Sincerely,

Director of Medical Assessment